HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-012

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252 and 42 CFR 447.280

7. FEDERAL BUDGET IMPACT:
a. FFY03 $ (1,981)
b. FFY04 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, pages 8 & 9

10. SUBJECT OF AMENDMENT:
Update of reimbursement methodology for intermediate care facilities for people with mental retardation

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jessie K. Rasmussen

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
July 15, 2002

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building
Des Moines, Iowa 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/02/02

18. DATE APPROVED: 12/31/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/02

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: CHARLENE BROWN

22. TITLE: Deputy Director, CMSO

23. REMARKS:

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

C. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (Cont.)

2. Accounting Procedures (Cont.)

c. Actual Allowable Cost and Rate Calculation

The actual allowable cost for ICFs/MR is the actual audited reported cost plus the inflation factor and incentive factor.

For community-based ICFs/MR, an occupancy factor is used in determining the actual per diem rate for the facility. Typically the per diem is arrived at by dividing the actual allowable reported costs by total patient days during the reporting period. Total patient days for purposes of rate determination are actual inpatient days or 80 percent of the licensed capacity of the facility, whichever is greater.

Effective July 1, 2002, for ICFs/MR, the owner/administrator compensation limits are $3,365 per month plus $35.90 for each bed over 60, for a maximum compensation not to exceed $4,986 per month.

New community-based ICFs/MR submit a six-month budget to generate an initial reimbursement rate for their first six months of operation. The budgeted financial and statistical reports do not receive inflation or incentive, but are limited to the maximum allowable cost ceiling.

Following six months of operation as a new community-based Medicaid-certified ICF/MR, the facility must submit a report of actual costs. This financial and statistical report is used to establish a rate which may include inflation but does not include an incentive.

The rate computed from this cost report is adjusted to 100 percent occupancy and continues to be subject to the maximum allowable cost ceiling. Business start-up and organization costs are amortized over a five-year period, according to Medicare and Medicaid standards.

All existing community-based facilities must report costs on a standard fiscal year of July 1 to June 30. Only one cost report is submitted per year.

State-owned ICFs/MR continue to submit semiannual cost reports and are not subject to the maximum allowable cost ceiling.